

12413

CERTIFICATE OF DEATH

12413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Char</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA, MD.</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Home Hosp.</u>		1 d. STREET ADDRESS <u>HILLTOP</u>	
3. NAME OF DECEASED (Type or print) First <u>BRADFORD</u> Middle <u>DAVIS</u> Last <u>DAVIS</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-US</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Jan 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self emp. Store owner. Charles County, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rufus Davis</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Barker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no. or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-8987</u>	
17. INFORMANT <u>Mrs. Katie V. Davis (Wife) - Hill Top, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Respiratory Collapse</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u> <u>2 wks.</u> <u>1 year.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 Nov</u> , 19 <u>58</u> , to <u>18 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>18 Nov</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>18 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		<u>LA PLATA, MD</u>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pisgah Methodist Church</u>	
22d. DATE THEREOF <u>11/21/1958</u>		22e. LOCATION (City, town, or county) (State) <u>Pisgah, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYLED TO STAFFORD, ENGLAND

WYED TO STAFFING OF THE

12414

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Westchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leplata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Kisco 69x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phy Man. Hopt.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CHARLES Robert FARUOLO</u>		4. DATE OF DEATH <u>NOV 4 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York City</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Robert</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes NOT KNOWN</u>	
17. INFORMANT <u>Edward Faruolo</u>		Address <u>New York City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Hemorrhoid</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>8 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-3</u> , 19 <u>58</u> to <u>11-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-24 AM</u> , 19 <u>58</u> , and that death occurred at <u>10:54 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>L A PLATA, Md</u> DATE SIGNED <u>11-4-58</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Kisco</u>	22d. LOCATION (City, town, or county) (State) <u>New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Signature]</u>		24a. REC'D BY REGISTRAR <u>NOV 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM BOND

Blank form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12415

CERTIFICATE OF DEATH

12415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata. Md.</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>A</u> First <u>DUDLEY</u> Middle <u>JACKSON</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-US</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 24 1876</u>
9. AGE (In years last birthday) <u>82</u> yn.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Wilfred Jackson</u>	
14. MOTHER'S MAIDEN NAME <u>Amanda Shorter</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217-14-7916</u>		17. INFORMANT Address <u>Mrs. Marvel Simpson, Wash, D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CUA</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>21 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 Nov</u> , 19 <u>58</u> , and that death occurred at <u>2:06 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>21 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity</u>	22d. LOCATION (City, town, or county) (State) <u>Newport, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 25 58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12410 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12416
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D.O.A. La Plata				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wills Last Lancaster				4. DATE OF DEATH Month November Day 16 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1918	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Attendant				10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (State or foreign country) Charles Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Lancaster				14. MOTHER'S MAIDEN NAME Mary Etta Wills			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-12-1641		17. INFORMANT Mrs. Mildred H. Lancaster, (Wife)		Address La Plata Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage Chest 823x DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Auto accident. DUE TO Auto accident.</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of auto which hit a bridge</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 11-16-58 11-16-58 11-16-58</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 20a) Driver of auto which hit a bridge			
20c. TIME OF INJURY Month, Day, Year 11-16-58 Hour 2 a. m. pm		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Bonanza Ches Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. J. Edelen				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. J. EDELEN				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/1958		22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Church Cemetery		22d. LOCATION (City, town, or county) (State) Chapel Point, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC.				ADDRESS LA PLATA, MARYLAND		24a. REC'D BY REGISTRAR NOV 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12417 CERTIFICATE OF DEATH

12417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aguasco</u> 16 x - 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Physicians Memorial Hosp</u>				d. STREET ADDRESS <u>16 x - 2</u>			
3. NAME OF DECEASED (Type or print) <u>Elsie E. Moreland</u>				4. DATE OF DEATH <u>Nov. 10, 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5, 1898</u> 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Higgs</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Robey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Albert Moreland</u> Address <u>Aguasco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 1970 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fibromyosarcoma of Neck</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>5 YRS.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>55</u> , to <u>Nov. 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>58</u> , and that death occurred at <u>12:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Parran Jarboe</u> M.D.				ADDRESS (Street, city or town, state) <u>La Plata, Md</u> DATE SIGNED <u>11-10-58</u>			
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Nov 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1910*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *J. H. Smith*

8. Signature of registrar: *W. B. Jones*

9. Name of informant: *John Doe*

10. Address of informant: *123 Main St*

11. Signature of informant: *J. Doe*

12. Date of filing: *Jan 16 1910*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12418

CERTIFICATE OF DEATH

12418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cobb Island</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Physician Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ELSIE MAY SMITH</i>		4. DATE OF DEATH <i>Nov 3 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jun 20, 1920</i>
9. AGE (In years last birthday) <i>38</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Expressman</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>James Conner</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Pringle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>W. M. Carnes</i>		Address <i>Cobb Island Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> DUE TO <i>330X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-31 1958</i> to <i>11-3 1958</i> that I last saw the deceased alive on <i>11-3 1958</i> , and that death occurred at <i>11:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frederick W. D.</i>		DATE SIGNED <i>11-3-58</i>	
PHYSICIAN'S NAME (Type) <i>Frederick W. D.</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>11-7-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Emmets Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>St Georges Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Greport Inc La Plata</i>		ADDRESS <i>La Plata</i>	
24a. REC'D BY REGISTRAR <i>NOV 7 58</i>		24b. REGISTRAR'S SIGNATURE <i>Chas S. D.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12419

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>TOMPKINSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mary Cornelia SWANN</u>		4. DATE OF DEATH <u>11-11-1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1, 1891</u>
9. AGE (In years for birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	11. IF UNDER 24 HRS Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hill</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Middleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>John Cecil Swann, Wash, D.C.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intraventricular Cerebral Hemorrhage</u>			
DUE TO (b) <u>Cerebral Arteriosclerosis</u>			
DUE TO (c) <u>15 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>No injury - onset at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-10-1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Tompkinsville, Charles, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>V.B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V.B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		22d. LOCATION (City, town, or county) (State) <u>Issue, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>		DATE	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12420 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First JUANITA Middle WASHINGTON Last WASHINGTON		4. DATE OF DEATH Month November Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1958
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	11. IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during major working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Ollie Monk		14. MOTHER'S MAIDEN NAME Agnes Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. -	
17. INFORMANT Agnes Washington		Address Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Otitis Media. 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Paul F. Guerin</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Piscataway, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home</i>		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
ADDRESS Waldorf, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

9VVVVVVXVV

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

Name of Person		Sex		Age		Date of Birth		Place of Birth		Municipality		County		State	
John Doe		Male		25		Jan 10, 1900		New York City		New York		New York		New York	
Mary Doe		Female		23		Jan 10, 1900		New York City		New York		New York		New York	
James Doe		Male		21		Jan 10, 1900		New York City		New York		New York		New York	
Elizabeth Doe		Female		19		Jan 10, 1900		New York City		New York		New York		New York	
Robert Doe		Male		17		Jan 10, 1900		New York City		New York		New York		New York	
Margaret Doe		Female		15		Jan 10, 1900		New York City		New York		New York		New York	
William Doe		Male		13		Jan 10, 1900		New York City		New York		New York		New York	
Mary Doe		Female		11		Jan 10, 1900		New York City		New York		New York		New York	
John Doe		Male		9		Jan 10, 1900		New York City		New York		New York		New York	
Elizabeth Doe		Female		7		Jan 10, 1900		New York City		New York		New York		New York	
Robert Doe		Male		5		Jan 10, 1900		New York City		New York		New York		New York	
Margaret Doe		Female		3		Jan 10, 1900		New York City		New York		New York		New York	
William Doe		Male		1		Jan 10, 1900		New York City		New York		New York		New York	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 (104)

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12421

12421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
Charles COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Indian Head, Md. HOSPITAL OR INSTITUTION OR STREET ADDRESS				MARYLAND LENGTH OF STAY (in this place) 5-Days STATE Maryland COUNTY Charles CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head Md STREET ADDRESS (If rural give location) 17 Cypress Place-Pot. Hts Indian Head Md.			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) Bruce (Middle) Thomas (Last) Weeks (Type or Print)				(Month) 11 (Day) 22 (Year) 58 OF DEATH			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	W-US	Single	3-4-57	1-yr. yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None				Washington-DC.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Earl Thomas Weeks				Audrey Weeks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Father-Earl Thomas Weeks			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
492X IMMEDIATE CAUSE (A) Pneumonia Broncho						2-Days	
ANTECEDENT CAUSE(S) DUE TO (B) Virus Infection						2-Days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Since birth	
Cerebral Palsy with Epileptic seizures							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-21-58, 19, to 11-22-58, 19, that I last saw the deceased alive on 11-22-58, 19, and that death occurred at 5 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
[Signature]				Indian Head, Md.		11-22-58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11/25/58		Bumpy Oak		Pomonkey, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
		Arthur S. [Signature]		The Hunt Funeral Home, W. [Signature]			
DATE							
NOV 28 '58							

THIS IS A COPY OF THE ORIGINAL RECORD OF THE NATIONAL BUREAU OF VITAL STATISTICS, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE. IT IS A COPY OF THE ORIGINAL RECORD OF THE NATIONAL BUREAU OF VITAL STATISTICS, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE. IT IS A COPY OF THE ORIGINAL RECORD OF THE NATIONAL BUREAU OF VITAL STATISTICS, U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE.

CERTIFICATE OF DEATH

1953

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

1953

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF WITNESSES	